

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *1865* *306*

1. PLACE OF DEATH- COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> *** COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cascade</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Catonsville</i> 3507 (or 08) Eastern Ave.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Ritchie Hospital</i>		STREET ADDRESS <i>116 Fursting Ave.</i>	
3. NAME OF DECEASED (First) <i>John</i> (Middle) <i>H. A.</i> (Last) <i>Armentrout</i>		4. DATE OF DEATH (Month) <i>Feb.</i> (Day) <i>17</i> (Year) <i>1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 20, 1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Steel worker</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>66</i> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <i>William Armentrout</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>unk.</i> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <i>unk.</i>	
17. INFORMANT AND ADDRESS <i>Hospital Record</i>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Hypertensive Cardio-vascular Disease</i>			<i>many yrs.</i>
Antecedent cause(s) (b) <i>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Carcinoma of Prostate gland</i>			<i>?</i>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Oct. 31*, 1950, to *Feb. 17*, 1951, that I last saw the deceased alive on *Feb. 17*, 1951, and that death occurred at *1:15 a.m.*, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Daniel Rai M.D. Ritchie Hospital, Cascade, Md. 2/17/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Interment</i>	<i>2-20-1951</i>	<i>Landon (Park)</i>	<i>Baltimore</i>	<i>Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>2/19/51</i>	<i>John P. Lohman</i>	<i>Leonard Ruck, 2411 N. Charles St.</i>	<i>Baltimore, Md.</i>	

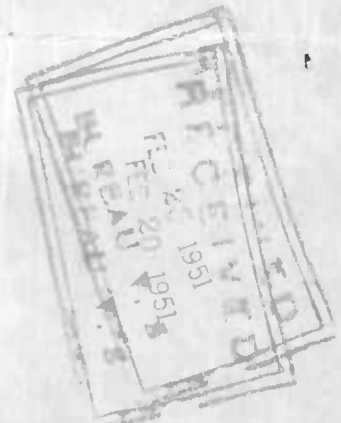
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

(4642 Walther Blvd.) *M. Shindle*
Information secured from stepson by phone - 3-8-51. ams (name of step-son
secured from the House In Pines)

above transferred to front: LL 3-9-51



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1886

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 420 W. Franklin St.		STREET ADDRESS (If rural, give location) 420 W. Franklin Street	
3. NAME OF DECEASED (Type or Print) Ida	(First)	(Middle)	(Last) Bailey
4. DATE OF DEATH Feb. 26, 1951	(Month)	(Day)	(Year)
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 10, 1866 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James W. McCurdy		14. MOTHER'S MAIDEN NAME Mary Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Mrs. Edna Miller		Hagerstown, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

4221

Immediate cause

(a) Cardio. Vascular System

5 yrs

932

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Rheumatism

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec 1 - 1950, to 2 - 26, 1951, that I last saw the deceased

alive on 2 - 24 - 51, and that death occurred atm., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 28, 1951	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Maryland	(State)
DATE REC'D BY LOCAL REG. Feb. 26, 1951	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Fred W. Kraiss	ADDRESS Hagerstown, Md	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		LENGTH OF STAY (in this place) 9 days		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		---Rural	
TOWN				STREET ADDRESS (If rural, give location) Near Kemps Mill			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hosp.							
3. NAME OF DECEASED (Type or Print)	(First) Oliver	(Middle) Lewis F.	(Last) Bartlett	4. DATE OF DEATH	(Month) Feb.	(Day) 2,	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 1878	9. AGE last birthday 72 yrs.	If under 1 year Months	If under 24 hrs. Days	If under 1 year Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY City		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-09-9178		17. INFORMANT AND ADDRESS Mrs. Helen Sigler Route 2, Hgst.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Apoplexy

INTERVAL BETWEEN ONSET AND DEATH

8 Days

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/26/51, 19....., to 2/2/51, 19....., that I last saw the deceased

alive on 2/2/51, 19....., and that death occurred at 3 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 5, 1951	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Maryland	(State)
DATE REC'D BY LOCAL REG. Feb. 5, 1951	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR Fred W. Kraiss	ADDRESS Hagerstown, Md.	

970936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change
in #9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1869

17
No. G 131 MAR 2 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Pennsylvania COUNTY Franklin	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural Big Spring (in this place) 2 Mo.		CITY (If outside corporate limits, write RURAL and give nearest town) Rural Greencastle	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Big Spring, Md. R D		STREET ADDRESS (If rural, give location) Greencastle, Pa. R D	
3. NAME OF DECEASED (Type or Print) Bessie May (First) (Middle) Bingaman (Last)		4. DATE OF DEATH (Month) (Day) (Year) Feby. 14, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Jan. 3 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE last birthday 72 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Greencastle, Pa.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ----- Hurshburger		14. MOTHER'S MAIDEN NAME Laura Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Mrs. Lyman Tosten- Big Spring, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause (a) Atherosclerotic-Hypertensive-heart-disease
93d Antecedent cause(s) (b) None
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION None 19b. MAJOR FINDINGS OF OPERATION None 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
INJURY
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?
OF While at Not While
INJURY Work ☐ At work ☐

22. I hereby certify that I attended the deceased from Dec. 30, 1950, to Feb. 14, 1951, that I last saw the deceased alive on Feb. 14, 1951, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
M D Clear Spring, Maryland 2-15-51

23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial Feb. 17-51 Broadfording Cemetery Near Cearfoss, Md.

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
Feb-15/1951 Joseph W. Murray A. E. Minnich- Greencastle, Pa.

MARGIN RESERVED FOR BINDING

VS. A15
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 23 1951
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1870 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hallway Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>23 East Lincoln Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ray</u> (First) <u>McClellan</u> (Middle) <u>Bowman</u> (Last)		4. DATE OF DEATH <u>Feb. 1</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13 1892</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charge of Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Dept. Union</u>	9. AGE last birthday <u>58</u> yrs. <u>9</u> Months <u>18</u> Days
11. BIRTHPLACE (State or foreign country) <u>Smithburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Joann Toms</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-3783</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Eva Bowman Ave. 23 East Lincoln Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x

Immediate cause

(a)

Antecedent cause(s)

83a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH
5 hrs

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY
m.INJURY OCCURRED While at Not While Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1/51, 19....., to 2/1/51, 19....., that I last saw the deceasedalive on 2/1/51, 19....., and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

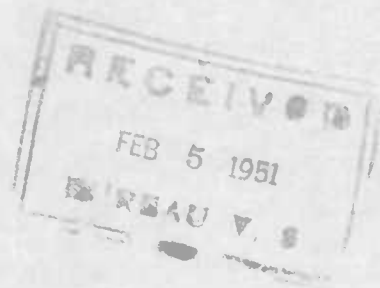
Feb. 2, 1951Robert V. Campbell MDHagerstown Md
Albert L. Leaf Williamsport Md.

554579

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition MARYLAND STATE DEPARTMENT OF HEALTH
if #21 shown on:

CERTIFICATE OF DEATH

FILE No. G 131 MAR 1 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. 1871 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Clear Spring, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS Route 40 W	
3. NAME OF DECEASED (Type or Print)	(First) Joseph	(Middle) Preston	(Last) Bridendolph
4. DATE OF DEATH	(Month) Feb.	(Day) 9,	(Year) 51
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Nov. 27, 1947
9. AGE last birthday 3 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel P. Bridendolph		14. MOTHER'S MAIDEN NAME Doris Irene Kimmel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Samuel P. Bridendolph			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		entire	
2nd & 3rd degree burns to body and extremities			
Immediate cause (a) 916.0			
Antecedent cause(s) 180			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) Home	(CITY OR TOWN) Near Clear Spring	(COUNTY) Wash.
(STATE) Md.			
TIME (Month) (Day) (Year) (Hour) OF INJURY Feb. 9 51	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? House caught fire probably from over-heated stove (3/1/51 acc)	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE S. P. Rakeit Mello, M.D.		ADDRESS 115 N. Potomac St. Hagerstown, Md.	
DEPUTY MEDICAL EXAM.		DATE SIGNED 2/10/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 12-51	NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	LOCATION (City, town, or county) Rural--Clear Spring, Md.
DATE REC'D BY LOCAL REG. Feb. 12, 1951	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR ADDRESS Adrian H. Rowland Clear Spring, Md.	

RECEIVED

U.S. DEPT. OF JUSTICE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1872 302

1. PLACE OF DEATH COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		CITY (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN RT. #1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL		STREET ADDRESS (If rural, give location) MEDWAY RD.	
3. NAME OF DECEASED (Type or Print)	(First) RICHARD	(Middle) LEE	(Last) BURGAN
4. DATE OF DEATH	(Month) FEBRUARY	(Day) 13	(Year) 51
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH 2/6/51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME ELMER L. BURGAN		14. MOTHER'S MAIDEN NAME ANNA E. NALLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. NONE	17. INFORMANT AND ADDRESS MR. ELMER L. BURGAN HAGERSTOWN RT. 1 Md.

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a)	Asphyxiation & asperation of fluid 1 hr	
Antecedent cause(s) (b)	Premature 6 1/2 mo	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/6/51, 19....., to 2/13/51, 19....., that I last saw the deceased alive on 2/14/51, 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/15/51	Rose Hill Cemetery	Hagerstown, Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
Feb 14 1951	Charles H. Bowers	W. J. Norment	Hagerstown, Md.	

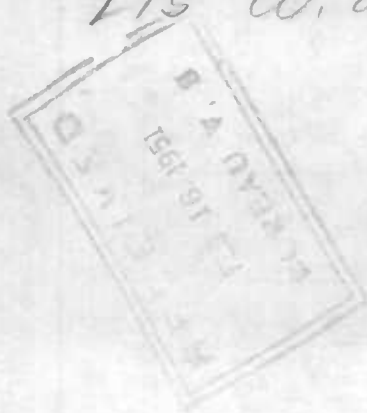
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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Little
215 W. Washington St.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1873

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Boonsboro		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Keedysville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Guilford Nursing Home		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) Osceola	(First) Winfield	(Middle) Burtner	(Last)
4. DATE OF DEATH Feb. 17 1951	5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Dec 15; 1864	9. AGE last birthday 86 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (State or foreign country) Chewsville, Md
12. CITIZEN OF WHAT COUNTRY? U. S.	13. FATHER'S NAME Ezra Burtner	14. MOTHER'S MAIDEN NAME Sarah Harp	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No
16. SOCIAL SECURITY No. None	17. INFORMANT Mr Howard Burtner	18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *Stry Gangrene of the left foot*
 (b) *Generalized Arteriosclerosis*
 (c)

INTERVAL BETWEEN ONSET AND DEATH

6 weeks.

5-yr plus

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 5, 1951, to Feb. 17, 1951, that I last saw the deceased

alive on Feb. 17, 1951, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Walter H. Shealy M.D. Sharpburg, Md. Feb. 17, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 20, 1951	Fair-View	Keedysville, Md	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
Feb. 20, 1951	John D. Burt	R. I. Earnshaw--Keedysville, Md		

290116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

1874

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>435 Carrollton Avenue</u>		STREET ADDRESS (If rural, give location) <u>435 Carrollton Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Andrew</u>	(Middle) <u>Conrad</u>	(Last) <u>Carbaugh</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>13</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 14, 1886</u>
9. AGE last birthday <u>64</u> yrs.	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>217-09-9797</u>	17. INFORMANT AND ADDRESS <u>Mrs. Edna Kershner- Hagerstown, Md.</u>

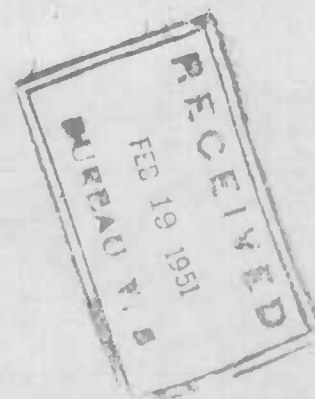
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>no cause the lungs</u>			
Antecedent cause(s) (b) <u>none</u>			
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>none</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>No</u>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 13/51</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>W. E. Beatty M.D.</u>		ADDRESS <u>Hagerstown, Md.</u>	DATE SIGNED <u>Feb 14</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 16-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Feb. 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>	ADDRESS <u>Hagerstown, Md.</u>

970246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



Dr. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesville Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesville Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chesville Md. Box 20</u>		STREET ADDRESS (If rural, give location) <u>Chesville Md. Box 20</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Clara</u>	(Middle) <u>J.</u>	(Last) <u>Clark</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 15, 1860</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>90-6-7 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Chesville Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel B. Bachtell</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Cross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Annie Lina Chesville Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Uremia</u>			<u>3 wks.</u>
Antecedent cause(s) (b) <u>Atherosclerosis & arteriosclerosis</u>			<u>years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma, Rectum</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>22 Feb</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>21 Feb</u> , 19 <u>51</u> , and that death occurred at <u>0730</u> m., from the causes and on the date stated above.			
SIGNATURE <u>John Dean Wilson M.D.</u>		ADDRESS <u>Smithsburg</u>	DATE SIGNED <u>2/23/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb. 24, 1951</u>	<u>Smithsburg Cemetery</u>	<u>Smithsburg Wash. Co. Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>FEB. 23, 1951</u>	<u>Chas. H. Bowers</u>	<u>Wm. F. Bast & Son</u>	<u>Baltimore Md</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Counter-signed
S. Robert Wells, M.D.
Feb. 15 '51
DEPUTY MEDICAL EXAM.
WASH. CO., MD.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles Street, Baltimore
CERTIFICATE OF DEATH

Dr Norment 1876
Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>		STREET ADDRESS <u>843 Summit Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>SUSAN</u> (First) <u>EMMA</u> (Middle) <u>CLOPPER</u> (Last)		4. DATE OF DEATH <u>Feb 13 1951</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug 18 1870</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wt. Carroll Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian G. Rauser</u>		14. MOTHER'S MAIDEN NAME <u>Martha A Deitrich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs H. Paul Bovey</u>		18. MEDICAL CERTIFICATION <u>843 Summit Ave Hagerstown Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>903.0</u> <u>Antero-sclerotic heart disease</u>		<u>years.</u>	
Antecedent cause(s) (b) <u>186a</u> <u>Fracture of right femur</u>		<u>2 months</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Vascular hypertension - generalized arterio sclerosis</u>		<u>year</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus - decubitus</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>Accident</u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u> (CITY OR TOWN) <u>Hagerstown</u> (COUNTY) <u>Washington</u> (STATE) <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec. 15. 1950 5 p.m.</u> INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Slipped on floor at home</u>			
22. I hereby certify that I attended the deceased from <u>Dec 15, 1950</u> , to <u>Feb. 13, 1951</u> , that I last saw the deceased alive on <u>Feb 13, 1951</u> , and that death occurred at <u>2:48 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr Norment</u>		ADDRESS <u>119 E Antietam St Hagerstown, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE <u>2/15/51</u> NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> LOCATION (City, town, or county) <u>Hagerstown Wash. Co Md</u> (State)			
DATE REC'D BY LOCAL REG. <u>Feb. 15, 1951</u> REGISTRAR'S SIGNATURE <u>Charles Bowers</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr. Hirshman

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>35 Lincoln Ave.</u>		STREET ADDRESS (If rural, give location) <u>35 Lincoln Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLES</u> (First) <u>ELLIS</u> (Middle) <u>CROMER</u> (Last)		4. DATE OF DEATH <u>Feb.</u> <u>5</u> <u>1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 3 1900</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector Fairchild</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Corp.</u>	9. AGE last birthday <u>50</u> Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor M Cromer</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Rhodes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>214-09-4122</u>	
17. INFORMANT AND ADDRESS <u>Mrs Mary Cole Cromer</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>35 East Lincoln</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
Immediate cause (a) <u>Coronary occlusion</u>					
Antecedent cause(s) (b) <u>Arteriosclerotic heart disease</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>---</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 4, 1951</u> to <u>Feb 4, 1951</u> , that I last saw the deceased alive on <u>Feb 4, 1951</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Thos. J. Holman</u>		ADDRESS <u>W.D. Hagerstown, Md.</u>		DATE SIGNED <u>2/5/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>2/7/1951</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>	
LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>		24. FUNERAL DIRECTOR <u>Andrew K Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	

533377

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1878

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>45 S. Potomac St.</u>		STREET ADDRESS (If rural, give location) <u>45 S. Potomac St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charlotte</u>	(Middle) <u>Virginia</u>	(Last) <u>Cusielski</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>3</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1919</u>
9. AGE last birthday <u>31</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Harry E. Arvin</u>		14. MOTHER'S MAIDEN NAME <u>Belle Ring</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Belle Clark</u>		<u>Hag. Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH 7

Immediate cause

(a) Broncho pneumonia

Antecedent cause(s)

(b) Acute alcoholic narcosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Brain tissue 0.47 ethyl alcohol

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY None

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

DEPUTY MEDICAL EXAMINER

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 10, 1951

Chas. H. Powers

Scott F. Minnich & Son Hag. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1879

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS <u>Knopville R. 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Rosa</u> (Middle) <u>C.</u> (Last) <u>Dairdson</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May-16-1875</u>
9. AGE last birthday <u>75-9-14 yrs.</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Capland Wash. Co. Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Oliver M. Younkine</u>	14. MOTHER'S MAIDEN NAME <u>Charlotte Kattell</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mrs. Kathryn Jones, Knopville Md. R. 1</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Pys. nephrosis, right</u>			
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Feb. 23, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Pys. nephrosis right kidney</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 23, 1951, to Feb. 24, 1951, that I last saw the deceased alive on Feb. 24, 1951, and that death occurred at 10:33 p.m., from the causes and on the date stated above.

SIGNATURE John A. Moran M.D. (Degree or title) ADDRESS 2/27/51 DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>Feb. 28-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Church of the Brethren Cemetery</u>	LOCATION (City, town, or county) (State) <u>Brownsville Wash. Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 27-1951</u>	REGISTRAR'S SIGNATURE <u>Frank H. Powers</u>	24. FUNERAL DIRECTOR <u>Wm. J. Best & Sons Brownsville Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
TOWN Hagerstown		TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 759 W. Washington		STREET ADDRESS (If rural, give location) 759 W. Washington	
3. NAME OF DECEASED (Type or Print)	(First) Eliza	(Middle) Elmin	(Last) Divvens
4. DATE OF DEATH	Feb.	(Day) 6	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec. 20, 1895
9. AGE last birthday 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner	
11. BIRTHPLACE (State or foreign country) Broadford Penn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas M. Magill		14. MOTHER'S MAIDEN NAME Ann Wyatte	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-32-2792	
17. INFORMANT AND ADDRESS John Magill		Youngwood Penn.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Carcinoma of Lung	3 yrs.
Antecedent cause(s) (b)	Carcinoma of Breast	1 yr.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
------------------------	----------------------------------	-----------------------------------------------------------------------

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1951 to Feb 6, 1951 that I last saw the deceased alive on Feb 6, 1951, and that death occurred at 10:05 p.m., from the causes and on the date stated above.

SIGNATURE H. H. Seachy, M.D. ADDRESS Hagerstown, Md. DATE SIGNED Feb 7, 1951

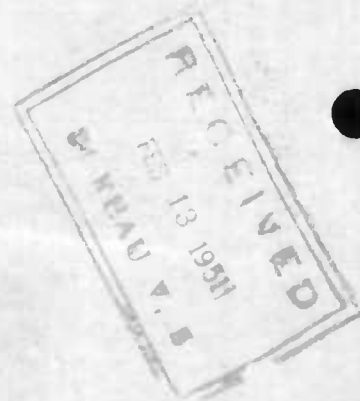
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF Feb. 9, 1951	NAME OF CEMETERY OR CREMATOR YOUNGWOOD	LOCATION (City, town, or county) Youngwood Penn.
DATE REC'D BY LOCAL REG. Feb. 8, 1951	REGISTRAR'S SIGNATURE H. H. Seachy, M.D.	24. FUNERAL DIRECTOR Scott F. Minnich & Son	ADDRESS Hag. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290 636



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Prince Georges</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
TOWN <u>Patche State Hos</u>		TOWN <u>South St</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>116 South St</u>		STREET ADDRESS <u>116 South St</u>	
3. NAME OF DECEASED (First) <u>Maggi</u> (Middle) <u>Duncan</u> (Last) <u>Duncan</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>65?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>unknown</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Hop Road</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Glomerulonephritis</u>			
Antecedent cause(s) (b) <u>Cerebral Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>334x 131b</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		INJURY	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF		While at Not While	
INJURY		Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 21, 1951, to Feb. 3, 1951, that I last saw the deceased alive on Feb. 2, 1951, and that death occurred at 4:29A m., from the causes and on the date stated above.

SIGNATURE Robert Bogan (Degree or title) MD ADDRESS 2135 DATE SIGNED 2/3/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>B.</u>	<u>2/7/51</u>	<u>St. Catharine</u>	<u>A.A. Co.</u>	<u>MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/6/51</u>	<u>A. W. Hedrick</u>	<u>Samuel W. Sullivan, Jr.</u>	<u>Belt Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>68 Wayside Avenue</u>		STREET ADDRESS (If rural, give location) <u>68 Wayside Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edward</u>	(Middle) <u>M.</u>	(Last) <u>Dutrow</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>9-30-1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>	9. AGE last birthday <u>82</u> yrs.
13. FATHER'S NAME <u>Daniel Dutrow</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Doll</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>NONE</u>	17. INFORMANT AND ADDRESS <u>Grace Dutrow, Hagerstown, Md.</u>

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Arterio sclerotic heart disease</u>			<u>16 days</u>
Antecedent cause(s) (b) <u>Generalized arterio sclerosis</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Acute bronchitis</u>			<u>16 days</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE <u>none</u>	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 18, 1951, to Feb. 3, 1951, that I last saw the deceased alive on Feb. 3, 1951, and that death occurred at 3:50 p m., from the causes and on the date stated above.

SIGNATURE R. J. Youment mo 1198 Antietam Dr Hagerstown Md 2/5/51
(Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-6-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Luthern Cemetery</u>	LOCATION (City, town, or county) (State) <u>Middletown, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Feb. 6, 1951</u>	REGISTRAR'S SIGNATURE <u>R. J. Youment</u>	24. FUNERAL DIRECTOR <u>C.M. Suter & Sons, Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290116

Dr. Norment



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Franklin</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penna.</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown, Md.</u> LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Greencastle</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>RD 6 - Chambersburg, Pa.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>DENNIS S. ECKSTINE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 24 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept. 9/1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday yrs. <u>3</u> 1/2
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roger Eckstine</u>		14. MOTHER'S MAIDEN NAME <u>Janet Shelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Roger Eckstine Chambersburg Rd.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Epithemic Influenza</u>		<u>1 wk.</u>
Antecedent cause(s) (b) <u>32b</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/15, 1951, to 2/24, 1951, that I last saw the deceased alive on 2/24, 1951, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

SIGNATURE <u>McBrewster</u>		ADDRESS <u>Greencastle, Pa.</u>		DATE SIGNED <u>2/25/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>2/26/51</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	
LOCATION (City, town, or county) (State) <u>Greencastle, Penna.</u>		24. FUNERAL DIRECTOR <u>A.E. Minnich</u>		ADDRESS <u>Greencastle, Penna.</u>	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. William Brewster



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1884

1. PLACE OF DEATH- COUNTY <u>WASHINGTON Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BOONESBORO</u> LENGTH OF STAY (in this place) <u>2 Mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GUILDFORD HOME</u>		STREET ADDRESS (If rural, give location) <u>2 RIDGE ROAD</u>	
3. NAME OF DECEASED (Type or Print) <u>SARAH</u> (First) <u>M.</u> (Middle) <u>GORDON</u> (Last)		4. DATE OF DEATH <u>February 14</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>4/20/861</u>
9. AGE last birthday <u>87</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Middletown Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>SANFORD EDMONSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY HOFF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. Lucille Latheman</u>	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

5 yrs.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 10, 1951, to Feb 14, 1951, that I last saw the deceasedalive on Feb 13, 1951, and that death occurred at 12:50 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1885

1. PLACE OF DEATH COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
TOWN <u>LIFE</u>		TOWN <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON COUNTY HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>221 S. POTOMAC ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LEE</u>	(Middle) <u>EDWARD</u>	(Last) <u>GUESSFORD SR.</u>
4. DATE OF DEATH	(Month) <u>FEBRUARY</u>	(Day) <u>17</u>	(Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9/27/1927</u>
9. AGE last birthday <u>23</u> yrs.	If under 1 year Months/ Days	If under 24 hrs. Hours/ Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL L. GUESSFORD</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE E. WARDEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>213-24-9943</u>	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>MRS. CATHERINE GUESSFORD</u> <u>HAGERSTOWN MD.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Chronic glomerulonephritis with uremia</u>	<u>Hemolytic anemia due to sytemial.</u>	<u>Several years</u>
Antecedent cause(s)	(b)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 5, 1951, to Feb. 17, 1951, that I last saw the deceased alive on Feb. 17, 1951, and that death occurred at 10:50 P. m., from the causes and on the date stated above.

SIGNATURE R. Bell M.D. ADDRESS Hagerstown, Maryland DATE SIGNED Feb. 14, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2/20/51</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown</u>	<u>MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb. 19, 1951</u>	<u>R. Bell</u>	<u>W. J. Wermant</u>	<u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970600



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>29 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Victor Products Plant</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS <u>748 W. Washington St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Franklin</u> (Middle) <u>Joseph</u> (Last) <u>Herrmann</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>8</u> (Year) <u>51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-6-1887</u>
9. AGE last birthday <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	
11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Franklin J. Herrmann</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schaffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>217-10-2614</u>	
17. INFORMANT <u>Mrs. Mary J. Herrmann</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) acute coronary occlusion

94a Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

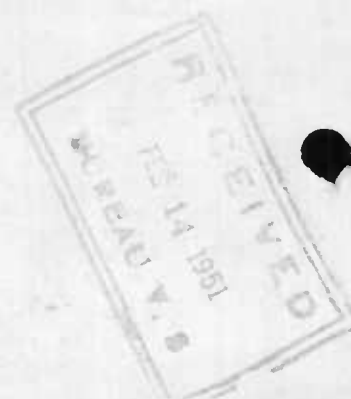
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-10-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb. 10, 1951</u>	REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>	ADDRESS <u>Hagerstown</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTRY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> <u>Washington</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>57 East Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Bertha</u> (Middle) <u>Florence</u> (Last) <u>Hoffhine</u>	4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3-14-1881</u>
9. AGE last birthday <u>69</u> yrs. If under 1 year <u>Mo</u> <u>Days</u> <u>20</u>		10. If under 24 hrs. <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of last year) <u>Ret. School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Hoffhine</u>		14. MOTHER'S MAIDEN NAME <u>Winters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Chas. Kepner, R.F.D.#2</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Nephritis with uraemia

INTERVAL BETWEEN ONSET AND DEATH

1 yr +

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Gastro enteritis (virus infecti)

5 days

(c) Virus Pneumonia

2 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Valvular Heart disease

10 yrs

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 29 Jan, 1951, to 4 Feb, 1951, that I last saw the deceased

alive on 4 Feb, 1951, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)
Burial

DATE THEREOF
2-7-1951

NAME OF CEMETERY OR CREMATORY
Cavetown Cemetery

LOCATION (City, town, or county) (State)
Cavetown, Maryland

DATE REC'D BY LOCAL REG.
Feb 6 1951

REGISTRAR'S SIGNATURE
Chas. Kepner

24. FUNERAL DIRECTOR

ADDRESS

C.M. Suter & Sons, Hagerstown, Md.

093888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Lusby



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1888

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Barnesboro Md. R.I.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda - Rural</u> STREET ADDRESS (If rural, give location) <u>Barnesboro Md. R.I.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Claude</u> (Middle) <u>Hollyday</u> (Last)	4. DATE OF DEATH <u>Feb. 24</u> (Month) <u>1951</u> (Day) <u>1951</u> (Year)	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 6, 1884</u>	9. AGE last birthday <u>66-9-18</u> yrs. Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Repair</u>
11. BIRTHPLACE (State or foreign country) <u>Barnesboro Wash. Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Samuel Hollyday</u>	14. MOTHER'S MAIDEN NAME <u>Alice Talbert</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>212-03-7014</u>	17. INFORMANT AND ADDRESS <u>Mrs. Lillian B. Hollyday Barnesboro Md. R.I.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary ThrombosisAntecedent cause(s) (b) 5 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 15, 1950, to Feb. 24, 1951, that I last saw the deceased alive on Feb. 19, 1951, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE W. D.

(Degree or title)

ADDRESS BarnesboroDATE SIGNED 2/26/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>Feb. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Funkhouser Cemetery</u>	LOCATION (City, town, or county) <u>Funkhouser Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 27, 1951</u>	REGISTRAR'S SIGNATURE <u>John H. Bait.</u>	24. FUNERAL DIRECTOR <u>Wm. J. Bait & Sons</u>	ADDRESS <u>Barnesboro Md</u>

310409

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



64
28
512
128
1792
200
1992

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1889

The correct age
is especially important. Supply every item of information carefully. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS (If rural, give location) <u>610 N. Carey St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Thomas</u> (Middle) <u>Ellsworth</u> (Last) <u>Hubbard</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 3, 1864</u>
9. AGE last birthday <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. CITIZEN OF WHAT COUNTRY? <u>res. A.</u>		13. FATHER'S NAME <u>Henry Phillip Hubbard</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine S. Marshall</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>	
16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT AND ADDRESS <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Robert Pneumonia</u>			<u>7 days</u>
Antecedent cause(s) (b) <u>Generalized Cerebro-sclerosis</u>			<u>many yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
SUICIDE HOMICIDE INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY m. <input type="checkbox"/> While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 23, 1948</u> to <u>Feb. 10, 1951</u> , that I last saw the deceased alive on <u>Feb. 10, 1951</u> , and that death occurred at <u>10:05 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Daniel Rai, M.D.</u>		ADDRESS <u>Ritchie Hospital, Cascade, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>buried</u>		DATE THEREOF <u>2/14/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Airy</u>		LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/13/51</u>		24. FUNERAL DIRECTOR <u>Wm. H. McLean</u> ADDRESS <u>1219 N. E. St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1890

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> <u>Washington</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>354 West Side Avenue</u>		STREET ADDRESS (If rural, give location) <u>354 West Side Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Frank</u> <u>Leslie</u> <u>Humelsine</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>12</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-28-1889</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Custodian</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>Canada</u>	
13. FATHER'S NAME <u>David Humelsine</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Binkley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-09-7836</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Frank L. Humelsine, Hagerstown</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acromyaly - R. duodenum tumor Stenosis

INTERVAL BETWEEN ONSET AND DEATH

40 yrs

Antecedent cause(s)

(b) growing wart. 18 mo ago
D. a. b. m. 3 m. later8 yrs(c) Cerebral arterio sclerosis3 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1949, to 12 Feb, 1951, that I last saw the deceased alive on 6 Feb, 1951, and that death occurred at 7:30 p m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-14-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb. 14, 1951</u>	REGISTRAR'S SIGNATURE <u>Frank H. Bowers</u>	24. FUNERAL DIRECTOR ADDRESS <u>C.M. Suter & Sons, Hagerstown, Md.</u>	

770906

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1891

CERTIFICATE OF DEATH

Reg. Dist. No. 305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bronsboro - Rural</u> TOWN <u>life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bronsboro R. 2</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bronsboro - Rural</u> TOWN <u>life</u> STREET ADDRESS (If rural, give location) <u>Bronsboro R. 2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harold</u>	(Middle) <u>Septimus</u>	(Last) <u>Hutchell</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 28 - 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>John Work</u>	9. AGE last birthday <u>80-6-19 yrs.</u>	11. BIRTHPLACE (State or foreign country) <u>Bronsboro Wash. Co. Md.</u>
13. FATHER'S NAME <u>John W. Hutchell</u>	14. MOTHER'S MAIDEN NAME <u>Laura Virginia Stevens</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT AND ADDRESS <u>Mrs. Ernest Dagenhart Bronsboro Md. R. 2.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause

(a)

Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

5 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY
m.INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 17, 1957, to Feb 17, 1957, that I last saw the deceasedalive on Feb 17, 1957, and that death occurred at 10 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

VS. A15

970116



MARYLAND STATE DEPARTMENT OF HEALTH

Dr Welty

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> LENGTH OF STAY (In this place) <u>5 Hrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sharpsburg</u> STREET ADDRESS (If rural, give location) <u>Snyders Landing</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOHN</u> <u>WILBUR</u> <u>INGRAM</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb</u> <u>22</u> <u>1951</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 11 1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Service Oil Co</u>	9. AGE last birthday <u>42</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Hancock Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Roy Ingram</u>		14. MOTHER'S MAIDEN NAME <u>Elva Kuhn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>214-10-1325</u>	
17. INFORMANT AND ADDRESS <u>Mrs Eloise Ingram</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>Boonsboro Md R #1</u> <u>% S.C. Kaylor</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u>	
Immediate cause (a) <u>Cerebral Haemorrhage</u>					
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>					
(c) <u>Hypertensive Vascular Disease</u>				<u>4 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from January, 1947, to February, 1951, that I last saw the deceased alive on Feb. 22, 1951, and that death occurred at 3:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Walter M. Welty M.D. Hagerstown Maryland

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2/24/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>	LOCATION (City, town, or county) (State) <u>near Clearspring Md</u>
DATE REC'D BY LOCAL REG. <u>FEB. 23. 1951</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Hager</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

490226



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sharpsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sharpsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chapel Street</u>		STREET ADDRESS (If rural, give location) <u>Chapel Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary</u> <u>Virginia</u> <u>King</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Feb.</u> <u>19</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 5 1860</u>
9. AGE last birthday <u>90</u> yrs.		10. If under 1 year Months <u>11</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Keedysville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Calman</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Heets</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS (daughter) <u>Mrs. Maggie Cook Sharpsburg Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

5 Yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized arteriosclerosis5 Yr. PlusII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1945, 19....., to 2/19, 19....., that I last saw the deceased 2/16/51 and that death occurred at 3:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 21 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Toison Church Cemetery</u>	LOCATION (City, town, or county) <u>Sharpsburg</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 21 1951</u>	REGISTRAR'S SIGNATURE <u>Edw. Rogers</u>	24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>	ADDRESS <u>Williamsport Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Guilford Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Franklin Co.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Rural</u> STREET ADDRESS (If rural, give location) <u>Waynesboro R. 4</u>	
3. NAME OF DECEASED (Type or Print) <u>Maude E. Kline</u>		4. DATE OF DEATH <u>February 7, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 28, 1878</u>
9. AGE last birthday <u>72-3-9 yrs.</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas S. Dusing</u>		14. MOTHER'S MAIDEN NAME <u>Elmyra Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Donald Kline Blue Ridge Summit Pa.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Renal Hemorrhage

Antecedent cause(s)

(b) Arterio Sclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Hemiparesis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Renovascular

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 12, 1951, to Feb. 7, 1951, that I last saw the deceased alive on Feb. 7, 1951, and that death occurred at 10:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>February 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Harbaugh Cemetery</u>	LOCATION (City, town, or county) <u>Franklin Co. Pa.</u>	(State)
DATE REC'D BY LOCAL REG. <u>February 9, 1951</u>	REGISTRAR'S SIGNATURE <u>John H. Baet</u>	24. FUNERAL DIRECTOR <u>Walter G. Brown</u>	ADDRESS <u>Waynesboro Pa.</u>	

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp.</u>		STREET ADDRESS (If rural, give location) <u>224 E. Washington Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Douglas</u>	(Middle) <u>Edward</u>	(Last) <u>Lewis</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Feb. 6, 1951</u>
9. AGE last birthday <u>7</u> yrs.		10. DATE OF DEATH <u>Feb. 7, 1951</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none infant</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Homer H. Lewis Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Doris E. Moats</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Homer H. Lewis Jr. Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Severe degree of intrauterine asphyxia due to

INTERVAL BETWEEN ONSET AND DEATH

1 day

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) compression of cord

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6 Feb, 1951, to 7 Feb, 1951, that I last saw the deceased alive on 6 Feb, 1951, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

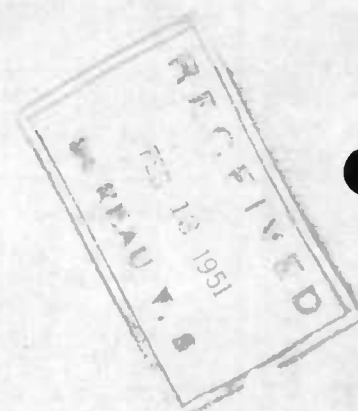
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 8, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>	LOCATION (City, town, or county) <u>Tilghmanton, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb. 8, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss Hagerstown, Md.</u>		

202061221407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



MARGIN RESERVED FOR BINDING

The correct age
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.
is especially important. Physicians: please write the causes of death clearly and legibly.

Counter signed
S. Robert Wells, M.D.
Feb. 11 1951
DEPUTY MEDICAL EXAMINER
WASH. CO., MD.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Evidence for change in
9 shown on: 1895
130 FEB 19 1951
Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerst own</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerst own</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 East Lee St.</u>		STREET ADDRESS <u>19 East Lee Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Philip Vincent Long</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 9 1951 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1 May 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Md. State Penal Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Guard</u>	9. AGE last birthday <u>38-37</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>W.O. Long</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes WW #2</u>		14. MOTHER'S MAIDEN NAME <u>Minnie A. Mason</u>	
16. SOCIAL SECURITY No. <u>214-09-9991</u>		17. INFORMANT AND ADDRESS <u>Hagerstown W.O. Long, 19 E. Lee Str. Md.</u>	

ASN-33 199260

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary artery disease

420.1 Antecedent cause(s)

940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. (c)

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 9, 1951, to Feb 9, 1951, that I last saw the deceased alive on Feb 9, 1951, and that death occurred at 11:15 A.m., from the causes and on the date stated above.
SIGNATURE W.D. Lyman, M.D. ADDRESS 5 Public Square Hagerstown, Md DATE SIGNED Feb 9 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2/12/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Dale Cemetery</u>	LOCATION (City, town, or county) <u>Martinsburg W. Va.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb 10, 1951</u>	REGISTRAR'S SIGNATURE <u>W.D. Lyman</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown Md</u>		

763926



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. *Joseph* Young

Reg. Dist. No. 1897 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>419 Fremont St.</u>		STREET ADDRESS (If rural, give location) <u>419 Fremont St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>FREDERICK</u> (Middle) <u>LEE</u> (Last) <u>LUSHBAUGH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feby 10 1951</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>June 6 1881</u>
9. AGE last birthday <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lushbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Katheraine Ridenour</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>214-09-1824</u>	
17. INFORMANT AND ADDRESS <u>Howard L. Lushbaugh</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <u>419 Fremont St. City</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>	
420.1 Immediate cause (a) <u>Coronary Occlusion</u>					
Antecedent cause(s)					
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u></u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c) <u></u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/8/51</u> , 19....., to <u>2/10/51</u> , 19....., that I last saw the deceased alive on <u>2/10/51</u> , 19....., and that death occurred at <u>11 p.m.</u> , from the causes and on the date stated above.					
SIGNATURE <i>Dr. Joseph Young</i>		(Degree or title) <i>W.D. Williams</i>		ADDRESS <i>Md. 21 157</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>2/13/51</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill cemetery</u>	
LOCATION (City, town, or county) <u>Hagerstown Wash. Co.</u>		24. FUNERAL DIRECTOR <i>Andrew K. Coffman</i>		ADDRESS <u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 12/1951</u>		REGISTRAR'S SIGNATURE <i>Frank Powers</i>			

970697

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1898

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>213 N. Mulberry Street</u>		STREET ADDRESS (If rural, give location) <u>213 N. Mulberry Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Anna</u> (Middle) <u>Elizabeth</u> (Last) <u>Lynn</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>25</u> , <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 25, 1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Renner</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Orville N. Lynn Hagerstown, Md.</u>		18. MOTHER'S MAIDEN NAME <u>Sarah Nicely</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma - Rt Breast</u>		<u>2 yrs.</u>
Antecedent cause(s) (b) <u>170x 50</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May 1950</u> to <u>Feb. 25, 1951</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>51</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.		
SIGNATURE <u>Theresa M. L. L...</u>	ADDRESS <u>Hagerstown Md</u>	DATE SIGNED <u>2/26/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>
LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>	(State)	
DATE REC'D BY LOCAL REG. <u>Feb. 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>
ADDRESS <u>Hagerstown, Maryland</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



111



The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

Countersigned
Feb. 2-51
S. Robert Wells, M.D.
DEPUTY MEDICAL EXAM.
WASH. CO., MD.

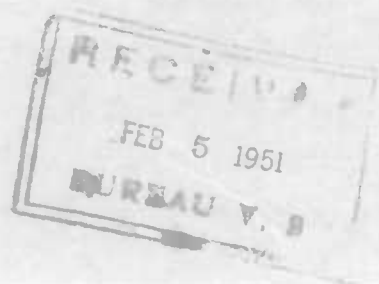
MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles Street, Baltimore
CERTIFICATE OF DEATH

1899

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND Md				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington			
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown				CITY (If outside corporate limits, write RURAL and give nearest town) Williamsport Maryland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital				STREET ADDRESS Church Street			
3. NAME OF DECEASED (Type or Print)		(First) Thomas		(Middle) Tynan		(Last) Mc Kelvey	
4. DATE OF DEATH		(Month) Feb.		(Day) 1		(Year) 1951	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Nov. 27, 1876	
9. AGE last birthday 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boatman C & O Canal		10b. KIND OF BUSINESS OR INDUSTRY C & O Canal		11. BIRTHPLACE (State or foreign country) Williamsport Md.	
13. FATHER'S NAME Alexander Mc Kelvey				14. MOTHER'S MAIDEN NAME Mary Singer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS Mrs. Mammie Swain (Sister) Williamsport Md.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
812.5 Immediate cause (a) Auto Accident						6 days	
1700 Antecedent cause(s) (b) Frac. Rt. Liliat Fibula Frac. Rt. Humerus							
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Frac. 3, 4, 5, 6, 7, 8, Ribs Right							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDAL ACCIDENT				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
PLACE (Home, farm, factory, street, OF office bldg., etc.)				21. ACCIDENT (Specify) SUICIDAL ACCIDENT			
HOMICIDE				HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY 1/26/51 7:15P.m.				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>			
HOW DID INJURY OCCUR? Hit By Auto While Crossing Street				CITY OR TOWN Williamsport (COUNTY) WASH. (STATE) Md.			
22. I hereby certify that I attended the deceased from 1/26/51, 19....., to 2/1/51, 19....., that I last saw the deceased alive on 2/1/51, 19....., and that death occurred at 7:00P.m., from the causes and on the date stated above.							
SIGNATURE E. F. Young				M.D. Williamsport Md.		DATE SIGNED 2/1/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial				NAME OF CEMETERY OR CREMATORY Riverview Cemetery			
DATE REC'D BY LOCAL REG. 2/1/51				24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.			

673246



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *302*

1. PLACE OF DEATH- COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Washington</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		LENGTH OF STAY (in this place) <i>1 month</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>	
TOWN <i>Hagerstown</i>				TOWN <i>Hagerstown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington County Hosp</i>				STREET ADDRESS (If rural, give location) <i>Woodmont</i>	
3. NAME OF DECEASED (Type or Print) <i>Alonzo Eugene Phelps</i>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <i>Feb. 18 1951</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	
8. DATE OF BIRTH <i>June 15-1878</i>		9. AGE last birthday <i>72</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>wood + painted shop</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Blacksmith</i>		13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
14. FATHER'S NAME <i>Charles Phelps</i>		15. MOTHER'S MAIDEN NAME <i>Mary Collins</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>	
17. SOCIAL SECURITY No. <i>none</i>		18. INFORMANT <i>Charles H. Phelps, Union Bridge Md</i>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Coronary Disease</i>					
Antecedent cause(s) (b) <i>Chol. Vatersclerosis, Bronchial Asthma</i>				<i>5 yrs?</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Chronic Bronchitis</i>					
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <i>Feb 17, 1951</i> , to <i>Feb 18, 1951</i> , that I last saw the deceased alive on <i>Feb 17, 1951</i> , and that death occurred at <i>3:30 A.M.</i> , from the causes and on the date stated above.		SIGNATURE <i>H. Crump</i>		ADDRESS <i>145 N. Washington St. Hagerstown Md.</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE <i>Feb 20-1951</i>		NAME OF CEMETERY OR CREMATORY <i>Mt View</i>	
LOCATION (City, town, or county) <i>Union Bridge Maryland</i>		(State) <i>Md.</i>			
DATE REC'D BY LOCAL REG. <i>Feb 18 1951</i>		REGISTRAR'S SIGNATURE <i>James D. Dwyer</i>		24. FUNERAL DIRECTOR <i>Del Hartley & Sons</i>	
ADDRESS <i>501817</i>				<i>Union Bridge & New Windsor, Md</i>	

Rec'd Feb 21, 1951 *Frank H. Bowers*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 23 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown LENGTH OF STAY (in this place) 20 years
TOWN Hagerstown
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1040 Pope Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown
TOWN Hagerstown
STREET ADDRESS (If rural, give location) 1040 Pope Avenue

3. NAME OF DECEASED (First) (Middle) (Last) Charles - William - Phillips
4. DATE OF DEATH (Month) (Day) (Year) February, 22, 1951

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed 8. DATE OF BIRTH Sept. 13, 1886 9. AGE last birthday 64-4-9 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Victor Prod. Corp. 11. BIRTHPLACE (State or foreign country) Yanqingburg Wash. Co. Md 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John C. Phillips 14. MOTHER'S MAIDEN NAME Ellen Hoffmaster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 214-09-0775 17. INFORMANT AND ADDRESS Mrs. Joseph Nease - 1040 Pope Ave. Hagerstown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral thrombosis2 wkAntecedent cause(s) (b) Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 8, 1951, to Feb. 23, 1951., that I last saw the deceased alive on Feb. 22, 1951., and that death occurred at 7:30 P.m., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

Robert W. Campbell M.D. Hagerstown Md 2/23/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Feb. 25, 1951 NAME OF CEMETERY OR CREMATORY Church of the Brethren Cemetery LOCATION (City, town, or county) (State) Brownsville Wash. Co. Md

DATE REC'D BY LOCAL REG. Feb. 24, 1951 REGISTRAR'S SIGNATURE Robert W. Campbell 24. FUNERAL DIRECTOR Wm. J. Bass & Sons ADDRESS Brownsville Md

970 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Robert Campbell

145 N. Charles



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sass Mar</u> TOWN <u>Sass Mar</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fahney Memorial Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Florida</u> COUNTY <u>Miami</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Miami</u> TOWN <u>Miami</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Clarence</u> (Middle) <u>George</u> (Last) <u>Pitner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 3, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>January 9, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milk Plant</u>	9. AGE last birthday <u>66-0-25 yrs.</u>
11. BIRTH PLACE (State or foreign country) <u>Berkeley Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dennis Pitner</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Sawyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>265-40-1170</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Corral E. Siefert-629 Winchester Ave. Martinsburg W. Va.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral Haemorrhage</u>		<u>12 hours</u>	
Antecedent cause(s) (b) <u>Hypertensive arteriosclerosis</u>		<u>10 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 3, 1951</u> , to <u>Feb 3, 1951</u> , that I last saw the deceased alive on <u>Feb 3, 1951</u> , and that death occurred at <u>4 PM</u> m., from the causes and on the date stated above.			
SIGNATURE: <u>G. Sullivan</u>		ADDRESS: <u>Boonsburg</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb 6, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>		LOCATION (City, town, or county) <u>Martinsburg W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>John A. East</u>		24. FUNERAL DIRECTOR <u>Kogelschatz & Coffman</u>	
		ADDRESS <u>Martinsburg W. Va.</u>	

763609

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FED B 1951
BUREAU T. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1302801

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29 W. Fredrick Street</u>		STREET ADDRESS (If rural, give location) <u>29 W. Fredrick Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Josephine Clagette Poffenbarger</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 10 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 15 1874</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Williamsport Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lancaster</u>		14. MOTHER'S MAIDEN NAME <u>Malinda Castle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lillian Adams Williamsport Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171x Immediate cause (a) Carcinoma - Ovary
48a Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(c)

INTERVAL BETWEEN ONSET AND DEATH
2 1/2 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov 43, 1943 to Feb 10, 1951, that I last saw the deceased alive on Feb 10, 1951, and that death occurred at 8 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 13 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	LOCATION (City, town, or county) <u>Williamsport Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb 13 - 1961</u>	REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>	24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>	ADDRESS <u>Williamsport Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Garrisonburg - Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Garrisonburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Knoxville Md. Box 54</u>				STREET ADDRESS (If rural, give location) <u>Knoxville Md. Box 54</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>John</u> (Middle) <u>Franklin</u> (Last) <u>Potter</u>		4. DATE OF DEATH		5. AGE last birthday	
				<u>February 15</u>		<u>81 yrs. 2 days</u>	
6. SEX <u>Male</u>	7. COLOR OR RACE <u>White</u>	8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	9. DATE OF BIRTH <u>Feb. 13, 1870</u>	10. AGE last birthday	If under 1 year	If under 24 hrs.	
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Farm Work</u>			
11. BIRTHPLACE (State or foreign country) <u>Garrisonburg Wash. Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Jackson Potter</u>				14. MOTHER'S MAIDEN NAME <u>Ireaca Anne Deane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT AND ADDRESS <u>Elizabeth G. Potter, Knoxville Md. Box 54</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral hemorrhage</u>						<u>1 wk.</u>	
Antecedent cause(s) (b) <u>Postmildotic gangrene - left foot</u>						<u>1 month</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Leukemia</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9</u> - <u>1948</u> , to <u>2-15, 1951</u> , that I last saw the deceased alive on <u>2-5-1951</u> , and that death occurred at <u>8:30 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> (Degree or title)				ADDRESS <u>Brownsville Md</u> DATE SIGNED <u>2-15-51</u>			
23. BURIAL, CREMATION (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 17, 1951</u>		<u>Church of the Brethren Cemetery</u>		<u>Brownsville Md.</u>	
DATE REC'D BY LOCAL REG. <u>2/17/51</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. J. Best & Sons</u>		ADDRESS <u>Brownsville Md</u>	

970116

RECEIVED
FEB 20 1951
BI KAU Y. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland Wash County	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 216 Summit Avenue		STREET ADDRESS 216 Summit Avenue (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Robert K. Pugh		4. DATE OF DEATH (Month) Feb. (Day) 13 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 8-21-1901
9. AGE last birthday 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk	
11. BIRTHPLACE (State or foreign country) Chambersburg, Pa.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME S. Huber Pugh		14. MOTHER'S MAIDEN NAME Catherine Heckman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 705-10-8599	
17. INFORMANT AND ADDRESS Mrs. Robert K. Pugh			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Carcinoma of bronchus.

2 months

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6 Dec., 1950, to 13 Feb., 1951, that I last saw the deceased

alive on 9 Feb., 1951, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION Burial (Specify)	DATE THEREOF 2-15-1951	NAME OF CEMETERY OR CREMATORY Norland Cemetery	LOCATION (City, town, or county) Chambersburg, Pa.	(State)
-------------------------------------------	---------------------------	---------------------------------------------------	-------------------------------------------------------	---------

DATE REC'D BY LOCAL REG. Feb. 14, 1951	REGISTRAR'S SIGNATURE G. H. Powers	24. FUNERAL DIRECTOR C.M. Suter & Sons, Hagerstown, Md.	ADDRESS
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390456

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>122 West Side Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Clarence</u> (First) <u>Jacob</u> (Middle) <u>Reecher</u> (Last)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>19</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-16-1897</u>
9. AGE last birthday <u>53</u> yrs.		10. If under 1 year: Months <u>3</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sen. H.H. School</u>	
11. BIRTHPLACE (State or foreign country) <u>Funkstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Reecher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schildnecht</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>214-09-9919</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Clarence Reecher, Funkstown</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Massive Hemorrhage from Oesophageal Varices

(b) Portal Cirrhosis of Liver

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 daysII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☒ No ☐

22. I hereby certify that I attended the deceased from May 2, 1949, to Feb. 19, 1951, that I last saw the deceased alive on Feb. 19, 1951, and that death occurred at 7:15 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) BurialDATE THEREOF 2-21-1951NAME OF CEMETERY OR CREMATORY Funkstown CemeteryLOCATION (City, town, or county) (State) Funkstown, MarylandDATE REC'D BY LOCAL REG. Feb 21, 1951REGISTRAR'S SIGNATURE Charles Bowers

24. FUNERAL DIRECTOR

ADDRESS C.M. Suter & Sons, Hagerstown, Md.

770888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Lusby

1957

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp/</u>		STREET ADDRESS (If rural, give location) <u>623 George St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>PHYLLIS DARLENE ROGERS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 28 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10/15/50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>	9. AGE last birthday <u>4</u> yrs. <u>13</u> Months <u>13</u> Days
13. FATHER'S NAME <u>Marvin Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Delores Hines</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>----</u>		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Marvin Rogers Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Immediate cause (a) <u>Broncho Pneumonia</u>			
Antecedent cause(s) (b) <u>108 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS (c) <u>Congenital Heart Disease</u>			
19a. DATE OF OPERATION <u>MM</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>W</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>26 Feb</u> , 19 <u>51</u> , to <u>28 Feb</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>28 Feb</u> , 19 <u>51</u> , and that death occurred at <u>9 30 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. J. Lusby</u>		ADDRESS	DATE SIGNED <u>2 Mar 51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>3/2/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar. 2, 1951</u>	REGISTRAR'S SIGNATURE <u>Black/Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

2 0150193 404

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> <u>Washington</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Clearspring Rt. #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>No Street Address</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Kreigh</u> (Middle) <u>Rowe</u> (Last)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>3-8-1879</u>
9. AGE last birthday <u>71</u> yrs.		10. AGE last birthday If under 1 year: <u>11</u> Months <u>15</u> Days If under 24 hrs: <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Dry Run, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel T. Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Dickerhoff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>John Franklin Rowe, Hagerstown</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331x Immediate cause (a) Cerebral Hemorrhage

83a Antecedent cause(s) (b) Hypertensive Sclerosis

giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

30 hrs.

5 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 12, 1951, to Feb. 13, 1951, that I last saw the deceasedalive on Feb. 13, 1951, and that death occurred at 10 m., from the causes and on the date stated above.SIGNATURE David R. Brewer M.D. ADDRESS Clear Spring Md. DATE SIGNED 2/16/51

23. BURIAL, CREMATION, or other disposal (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2-17-1951</u>	<u>Fairview Cemetery,</u>	<u>Fairview, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb. 16, 1951</u>	<u>Chas. H. Hower</u>	<u>C. M. Suter & Sons,</u>	<u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Brewer



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1951

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
TOWN Hagerstown		TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 309 Valley Road		STREET ADDRESS (If rural, give location) 309 Valley Road	
3. NAME OF DECEASED (First) Manie (Middle) Susan (Last) Rudisill		4. DATE OF DEATH (Month) Feb. (Day) 16 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept 18, 1884
9. AGE last birthday 66 yrs.		10. UNDER 1 year 11 under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John L. Miner		14. MOTHER'S MAIDEN NAME Catherine Bowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - -	
17. INFORMANT AND ADDRESS Tony Rudisill Hag. Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

180x Immediate cause (a) Arterio-sclerotic myocardial heart disease

52a Antecedent cause(s) (b) Hypernephroma (left kidney)

(c) 2yrs

1yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Jan. 13 '51		19b. MAJOR FINDINGS OF OPERATION Hypernephroma left kidney		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) no		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr. 29, 1950, to Feb. 16, 1951, that I last saw the deceased alive on Feb. 15, 1951, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Feb. 19, 1951		NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		LOCATION (City, town, or county) Hagerstown Md.	
DATE REC'D BY LOCAL REG. Feb. 19, 1951		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hag. Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 21 1961
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr. Keadle

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1910

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital.</u>		STREET ADDRESS (If rural, give location) <u>Ridge Ave. Extd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Terese</u> (Middle) <u>Ann</u> (Last) <u>St Clair.</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 8/ 1949</u>
9. AGE last birthday <u>1</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert St Clair</u>		14. MOTHER'S MAIDEN NAME <u>Annie Heusley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Albert St Clair Hagerstown Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 mo</u>
Immediate cause <u>4912</u> <u>Antecedent cause(s)</u> <u>157d</u> <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	(a) <u>Bronchopneumonia rt</u> (b) <u>Malnutrition</u> (c) <u>Microcephalic idiot</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-18, 1949, to 2-7, 1951, that I last saw the deceased

alive on 2-6, 1951, and that death occurred at 11:39 A m. from the cause and on the date stated above.

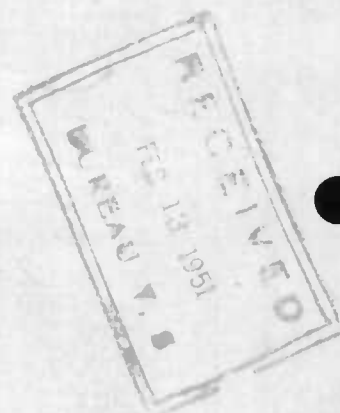
SIGNATURE Robert F. Keadle M.D. (Degree or title) ADDRESS 132 W. WASHINGTON ST. HAGERSTOWN, MARYLAND DATE SIGNED 2-8-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/9/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
DATE REC'D BY LOCAL REG. <u>Feb. 9, 1951</u>	REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	24. FUNERAL DIRECTOR ADDRESS <u>Andrew K. Coffman. Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		LENGTH OF STAY OR 25 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Intervale Road				STREET ADDRESS (If rural, give location) Intervale Road	
3. NAME OF DECEASED (Type or Print)		(First) Frank	(Middle) R.	(Last) Schelle	4. DATE OF DEATH (Month) Feb. (Day) 13 (Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed		8. DATE OF BIRTH 10-10-1874	9. AGE last birthday 76 yrs. 4 Months 3 Days 4 Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hoisting Operator		10b. KIND OF BUSINESS OR INDUSTRY Bester & Long		11. BIRTHPLACE (State or foreign country) Jackson Center, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Schelle		14. MOTHER'S MAIDEN NAME Annie Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-1676		17. INFORMANT AND ADDRESS Miss Anna Schelle, Hagerstown	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) **Coronary Thrombosis**

Antecedent cause(s)

94a Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 13 1951** to **Feb 13 1951**, that I last saw the deceasedalive on **Feb 13 1951** and that death occurred at **3:30 P.M.** from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb 16 1951**Frank H. Bester****P.M. Suter & Sons, Hagerstown, Md.**

513 V V

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. J. H. Beachley



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1912

1. PLACE OF DEATH- COUNTY <u>Wash County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Lehensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lehensville Md Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>		STREET ADDRESS <u>none</u> (If rural give location) <u>Lehensville Md-Rural.</u>	
3. NAME OF DECEASED (First) <u>Herbert</u>	(Middle) <u>none</u>	(Last) <u>Snyder</u>	4. DATE OF DEATH (Month) <u>2-</u> (Day) <u>23-</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April-16th 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Hand</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>Jacob Snyder</u>		12. CITIZEN OF WHAT COUNTRY? <u>Washington</u>	
13. MOTHER'S NAME <u>Catharine Anna. Prox</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Herbert. F. Snyder. Jr</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
447x Immediate cause (a) <u>Acute Pulmonary Edema</u>			<u>4 hours</u>
Antecedent cause(s) (b) <u>Arteriosclerosis - Hypertension</u>			<u>years</u>
97 Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug., 1950, to Dec., 1950, that I last saw the deceased alive on Dec., 1950, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

SIGNATURE <u>John Dean Wilson M.D.</u>	(Degree or title)	ADDRESS <u>Smithsburg</u>	DATE SIGNED <u>2/24/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb 26th</u>	NAME OF CEMETERY OR CREMATORY <u>Bonsboro Cemetery</u>	LOCATION (City, town, or county) (State) <u>Town of Boonsboro Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 25, 1951</u>	REGISTRAR'S SIGNATURE <u>Phas H. Hower</u>	24. FUNERAL DIRECTOR <u>Geo B. Hower</u>	ADDRESS <u>Smithsburg Md</u>

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1913

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>326 E. Franklin St.</u>		STREET ADDRESS (If rural, give location) <u>326 E. Franklin St.</u>	
3. NAME OF DECEASED (First) <u>Joseph</u> (Middle) <u>Ray</u> (Last) <u>Stevenson</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 29, 1950</u>
9. AGE last birthday <u>4</u> yrs. <u>18</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph C. Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Oneida Kephart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>----</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Oneida Stevenspn</u>		<u>Hag. Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hydrocephalus

INTERVAL BETWEEN ONSET AND DEATH

2 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>murder</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 15 Nov, 1950, to 17 Feb, 1951, that I last saw the deceasedalive on 15, 1951, and that death occurred at 4:15 p.m., from the causes and on the date stated above.SIGNATURE J. J. Lusby

(Degree or title)

ADDRESS 2301 N. PotomacDATE SIGNED 19 Feb 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE TIME REOF <u>Feb. 20 - 51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb. 19, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>	ADDRESS <u>Hag. Md.</u>	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1914

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lema</u> TOWN <u>Rural</u> STREET ADDRESS <u>Bourusho md. R. 2</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Katherine</u> (Middle) <u>Anna</u> (Last) <u>Swape</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 16, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>39</u> yrs. If under 1 year Months <u>8</u> Days <u>12</u> If under 24 hrs. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>Beaver Creek Wash. Co. md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mary</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Bowens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-09-4655</u>	
17. INFORMANT AND ADDRESS <u>Arthur J. Swape Bourusho md. R. 2</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Generalized Metastases</u>	Antecedent cause(s) (b) <u>Carcinoma Left Breast</u>	<u>Nov 1948</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>Nov 4-1948</u> 19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Left Breast</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

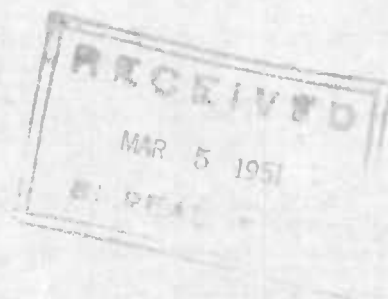
22. I hereby certify that I attended the deceased from Nov 12, 1948, to Feb 28, 1951, that I last saw the deceased alive on Feb 28, 1951, and that death occurred at 2:12 P.m., from the causes and on the date stated above.

SIGNATURE Edgar Winsten (Degree or title) M.D. J. Edgar Winsten ADDRESS 3-2-51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 4, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Lema Cemetery</u>	LOCATION (City, town, or county) <u>Mt. Lema Wash. Co. md.</u>
DATE REC'D BY LOCAL REG. <u>Mar 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Edgar Winsten</u>	24. FUNERAL DIRECTOR <u>Wm. J. Best & Sons</u>	ADDRESS <u>Bourusho md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1915

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Sharpsturg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural--Sharpsturg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Walker</u>	(Middle) <u>Talbert</u>	(Last) <u>Thomas</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>8</u> <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 9, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>70</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Keedysville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alfred Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>Unknown</u>) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Vernon Knode</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

5 yrs.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 5, 1951, to Feb 8, 1951, that I last saw the deceasedalive on Feb 5, 1951, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb 12, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Briar</u>	LOCATION (City, town, or county) <u>Mt. Briar-Wash.-Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb 10 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>R. I. Earnshaw--Keedysville, Md</u>		

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAR 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Fairground Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hagerstown</u> TOWN STREET ADDRESS (If rural, give location) <u>15 Fairground Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Emma</u> (Middle) <u>Katherine</u> (Last) <u>Toms</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>1</u> (Year) <u>1951</u>	
6. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <u>WIDOWED</u> (Specify)	8. DATE OF BIRTH <u>June 16, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mln.
11. BIRTHPLACE (State or foreign country) <u>Rockdale Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Lum</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Hose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT AND ADDRESS <u>Roger J. Toms Hag. Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) <u>Arterio-sclerotic coronary heart disease</u>	6 days
Antecedent cause(s) (b) <u>Acute coronary occlusion</u>	
940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>NO</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1950, to Jan 31, 1951, that I last saw the deceased alive on Jan 31, 1951, and that death occurred at 6:15a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

S. Robert Wells M.D.115 N. Potomac St. Hagerstown, Md.Feb. 2, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 3, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb. 2, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>	ADDRESS <u>Hag. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Evidence for addition
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1917

CERTIFICATE OF DEATH

Reg. Dist. No. 300

FHM No. G 131 MAR 15 1951

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wasa.	
CITY (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		CITY (If outside corporate limits, write RURAL and give nearest town) Sharpsburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) Joan (Middle) Elaine (Last) Turner		4. DATE OF DEATH (Month) Feb. (Day) 8 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH July 16, 1945
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 5 years
11. BIRTHPLACE (State or foreign country) Hagerstown, Md		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Albert Turner		14. MOTHER'S MAIDEN NAME Helen Hagan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No	
(If yes, give war or dates of service)		17. INFORMANT Mrs. Helen Brashears	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Brain Tumor

INTERVAL BETWEEN ONSET AND DEATH

3 yrs.

Antecedent cause(s)

(b)

No further information (3/15/51 aka)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 7, 1948, to Feb 8, 1951, that I last saw the deceased

alive on Feb. 5, 1951, and that death occurred at 2:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 10 1951	Mt. View	Sharpsburg, Md	

DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 10 1951	[Signature]	R. I. Earnshaw--Keedyville, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1918

1. PLACE OF DEATH- COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE PENNSYLVANIA COUNTY CUMBERLAND	
CITY (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) RURAL SHIPPENSBURG	
TOWN MAUGANSVILLE		TOWN SHIPPENSBURG	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MAUGANSVILLE		STREET ADDRESS RT. #3	
3. NAME OF DECEASED (First) MARY (Middle) E. (Last) WADEL		4. DATE OF DEATH (Month) FEB. (Day) 12 (Year) 1951	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH 8/8/1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN WADEL		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, NO unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. NONE	
17. INFORMANT AND ADDRESS MR. WALTER WADEL		SHIPPENSBURG, PA.	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Carcinoma of Stomach		with Liver Metastasis	1 year.
Antecedent cause(s) (b) 151X 46b			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jan. 10, 1950**, to **Feb. 12, 1951**, that I last saw the deceased alive on **Feb. 10, 1951**, and that death occurred at **4 P.** m., from the causes and on the date stated above.

SIGNATURE W.D. Shively, M.D.	DATE SIGNED 2/13/51			
ADDRESS 148 W. Wash. Hagerstown Md				
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/15/51	NAME OF CEMETERY OR CREMATORY Howe Cemetery	LOCATION (City, town, or county) Shippensburg Penn.	(State)
DATE REC'D BY LOCAL REG Feb 13, 1951	REGISTRAR'S SIGNATURE W.D. Shively	24. FUNERAL DIRECTOR W.D. Shively	ADDRESS Hagerstown, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 906

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Smithsburg md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Smithsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smithsburg md #1</u>		STREET ADDRESS (If rural give location) <u>Smithsburg md #1</u>	
3. NAME OF DECEASED (First) <u>Nettie</u>	(Middle) <u>Ketavich</u>	(Last) <u>West</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 19, 1957</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Sept 12 1861</u>
9. AGE last birthday <u>89</u> yrs.		10. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		12. BIRTHPLACE (State or foreign country) <u>Halville Frederick Co Md.</u>	
13. FATHER'S NAME <u>Jacob Ridenour</u>		14. MOTHER'S MAIDEN NAME <u>Hesiah Stottlemeyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(U) yes, give war or dates of service</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Miss Maude West Smithsburg md #1</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinomatosis</u>		<u>3 wks</u>
Antecedent cause(s) (b) <u>155x Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
(c) <u>Carcinoma of Liver</u>		<u>7 mos</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 30 1957, to Feb 19 1957, that I last saw the deceased alive on Feb 19, 1957, and that death occurred at 10:45 P. m., from the causes and on the date stated above.

SIGNATURE <u>G. G. K. Kohler</u>		ADDRESS <u>MD Smithsburg</u>		DATE SIGNED <u>2/20/57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/23/57</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	LOCATION (City, town, or county) <u>Waynesboro Pa.</u>	(State) <u>md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 22-57</u>	REGISTRAR'S SIGNATURE <u>Geo. W. Ferguson</u>	24. FUNERAL DIRECTOR <u>Walter G. Grove</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Wells

1920

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> LENGTH OF STAY (In this place) <u>12 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>216 East Franklin St.</u>	
3. NAME OF DECEASED (Type or Print) <u>ELMER</u> (First) <u>MARTIN</u> (Middle) <u>WHIPP</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Feby 1 1951</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr 14 1872</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler- Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Braddock Heights Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George C. Whipp</u>		14. MOTHER'S MAIDEN NAME <u>Annie Morrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) --		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Herbert C. Whipp</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Reynaud's disease</u>			<u>6 yrs.</u>
Antecedent cause(s) (b) <u>Chronic myocarditis</u>			<u>8 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Congestive myocardial heart failure</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Failure</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>no</u> PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u> INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July, 1944, to Feb. 1, 1951, that I last saw the deceased alive on Jan. 31, 1951, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Wash. Co. Md</u>
DATE REC'D BY LOCAL REG. <u>Feb 3, 1951</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg. Dist. No. 302

Reg. Dist. No. 302

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										18. MEDICAL CERTIFICATE		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause				(a) <u>Ch. Myocarditis</u>									
Antecedent cause(s)				(b) <u>4222</u>									
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last				(c) <u>93d</u>									
11. OTHER SIGNIFICANT CONDITIONS													
Conditions contributing to the death but not related to the disease or condition causing death.													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?					
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY				(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>				HOW DID INJURY OCCUR?					

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/7/51	Fairview, Md.	Fairview, Md.	
DATE RECD BY LOCAL REG	REGISTRAR'S SIGNATURE	24/ FUNERAL DIRECTOR	ADDRESS	
Feb. 6, 1951	Wm. H. Howard	A. E. Minnich	Greensboro, N.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

ditto



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>650 N. Mulberry St.</u>		STREET ADDRESS (If rural, give location) <u>650 N. Mulberry St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Bessie F. Wiles</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>3</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>7-12-1880</u>
9. AGE last birthday <u>70</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Gladhill</u>		14. MOTHER'S MAIDEN NAME <u>Magdalene Kenina</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Luther Wiles, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

2-3 years

Antecedent cause(s)

(b)

Coronary - Vascular Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1, 1930, to 2/3, 1951, that I last saw the deceased alive on 2/3, 1951, and that death occurred at 11 a.m., from the causes and on the date stated above.

SIGNATURE <u>L. B. D. Miller</u>		DATE SIGNED <u>2/5-1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-6-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	LOCATION (City, town, or county) (State) <u>Middletown Md</u>
DATE REC'D BY LOCAL REG. <u>Feb. 6, 1951</u>	REGISTRAR'S SIGNATURE <u>Phyllis Flowers</u>	24. FUNERAL DIRECTOR <u>Gladhill Co.</u>	ADDRESS <u>Middletown, Md.</u>

MARGIN RESERVED FOR BINDING

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VS. A15

928 Miller Co. 13mrs



131 w
Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr wells

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> LENGTH OF STAY (In this place) <u>10 Hrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>112 East Baltimore St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EARL</u> (Middle) <u>PRESTON</u> (Last) <u>WOLFE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feby 5 1951</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feby 24 1890</u> 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>First Floor Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leiter Bros</u>	11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>
13. FATHER'S NAME <u>Walter Wolfe</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Leiter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If year, give year or dates of service) <u>W.#1</u>		16. SOCIAL SECURITY No. <u>214-09-0614</u>	
17. INFORMANT AND ADDRESS <u>Ross L. Wolfe</u> <u>112 E. Baltimore St</u> <u>Hagerstown Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>138.0 Suspected sarcoid of lungs</u>		<u>Feb. 1950</u>	
Antecedent cause(s) <u>57.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		<u>(b) Asphyxia due to above</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Aug. 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Bronchoscopic & excision of lymph nodes</u>	
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>OMICIDE</u> <u>no</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> <u>—</u> <u>—</u> <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Sept. 29, 1950</u> , to <u>Feb. 5, 1951</u> , that I last saw the deceased alive on <u>Feb. 5, 1951</u> , and that death occurred at <u>8:30 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>S. Robert Wells MD.</u>		ADDRESS <u>115 N. Patomac St.</u> <u>Hagerstown Md.</u>	
DATE <u>Feb. 8, 1951</u>		DATE SIGNED <u>2/6/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>2/8/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md</u>	

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

205VVV

